New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Marriage and Family Therapy Examiners
124 Halsey Street, 6th Floor, P.O. Box 45007
Newark, New Jersey 07101
(973) 504-6415

Application for Three-Year Temporary Permit

OBJECTIVE

All applicants for licensure as a Marriage and Family Therapist must meet the required academic requirements, have three (3) full years of counseling experience including two (2) full years of supervised marriage and family therapy (M.F.T.) client contact, and complete the required criminal history background check (N.J.S.A. 45:8B-18(b) and N.J.S.A. 45:1-28 et seq.). After those requirements are met and approved, the applicant is admitted to take the Association of Marital and Family Therapy Regulatory Board's (A.M.F.T.R.B.) Examination in Marital and Family Therapy. This permit does not apply to the required one year of (general) counseling. You will be required to show the completion of (general) counseling hours (N.J.S.A. 45:8B-18(b) and N.J.A.C. 13:34-4.3) when you submit the final application for licensure. Your academic requirements, Clinical M.F.T. Supervision Plan, and criminal history background check will all be reviewed by the Board as part of the permit application. Permit holders who remain in good standing with their approved supervisor and the Board can be assured that they will be acquiring experience that will allow them to be admitted to take the A.M.F.T.R.B. Examination in M.F.T., and once they pass that, to be eligible for M.F.T. licensure.

INSTRUCTIONS

Pursuant to N.J.A.C. 13:34-4.3(b), each year of supervised M.F.T. experience is quantified as 1,000 client contact hours, 200 hours of supervision and 300 hours of work-related activities, for a total of 1,500 hours. A year is defined as 50 weeks. Therefore, each FULL week consists of 20 hours of face-to-face contact with clients, four hours of supervision (one hour of supervision for each five hours of client contact provided by an approved supervisor), and at least six hours of work-related activities. "Work-related activities" are defined to include preparing and maintaining client records as described in N.J.A.C. 13:34-8.1 through 8.3, report writing, maintaining appointment schedules, communicating with other professionals, preparing for supervision, preparing and maintaining financial records in accordance with N.J.A.C. 13:34-5.3 and 6.1, and any other activities the qualified supervisor deems appropriate.

The Board recommends that you keep a well-defined record of client contact hours, supervisory hours and other work-related hours. See the attached Semi-Annual Report Form.

The Clinical M.F.T. Supervision Plan (see the attachment) is the basis upon which the Board authorizes clinical experience with clients, approves the supervisor(s), and is assured that the proposed years of practical experience will provide the best possible basic preparation for your licensed practice as a Marriage and Family Therapist. The Board must pre-approve the supervisor(s). Credit will not be given for supervisory hours by an unqualified supervisor. This plan is a critical piece of your permit application. **The Board is mandated by law to insure that New Jersey consumers are provided with qualified Marriage and Family Therapists who have been appropriately and adequately prepared for the independent practice of marriage and family therapy.**

Attach a clear, full-face passport-style photograph (2″x 2″) of your head and shoulders, taken within the past six months.

A photo is required with each application.

Do not use staples to attach the photo.

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Application for Three-Year Temporary Permit

A nonrefundable application filing fee of $75, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Board maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last name | First name | Middle initial | Maiden name

2. Address

   ☐ Home: _____
   Street or P.O. Box | City | State | ZIP code | County

   _____ _____
   Telephone number (include area code) | E-mail address

   ☐ Business: _____
   Name of company | Telephone number (include area code)

   _____
   Street | City | State | ZIP code | County

   ☐ Mailing: _____
   Street or P.O. Box | City | State | ZIP code | County

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

*Social Security Number: _____ -_____ - _____

*Pursuant to N.J.S.A. 54:50-24 et. seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issue your student loan, for the eventual repayment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for repayment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

a. Do you currently have a child-support obligation? ☐ Yes ☐ No

(1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No

(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____	_____	_____
Applicant's name (please print)	Applicant's signature	Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice marriage and family therapy" is to be construed to include all of the following:

a. The cognitive capacity to exercise reasonable marriage and family therapy judgments and to learn and keep abreast of professional developments; and

b. The ability to communicate those judgments and professional information to clients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform the duties of a marriage and family therapist, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substance" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the previous two years.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**?
☐ Yes ☐ No ☐ Not applicable

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable

d. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable

e. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
☐ Yes ☐ No

f. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐ Yes ☐ No

If you answered "Yes" to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

Applicant's signature _____ Date _____

8. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

9. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

   If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

10. Do you currently hold, or have you ever held a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. _____
    Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

11. Have you ever been disciplined or denied a professional license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

12. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Have you ever been named as a defendant in any litigation related to the practice of marriage and family therapy or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of marriage and family therapy or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 11 through 17, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education (Complete all that apply.)

Undergraduate degree	Name of granting institution	Year granted
Address	Major/Minor	

Graduate degree	Name of granting institution	Year granted
Address	Major/Minor	

Graduate degree	Name of granting institution	Year granted
Address	Major/Minor	

C.O.A.M.F.T.E.- Accredited Institution or Training Program:
Some applicants will have "a graduate degree in a related field which does not provide training and coursework substantially equivalent in content to a master's degree in marriage and family therapy" (N.J.S.A.: 45:88-18(a)) (not a master's degree in marriage and family therapy nor a master's degree in social work) and will have training at an institute or training program not affiliated with an accredited university. If that institute is accredited by the Commission on Accreditation for Marriage and Family Therapy (C.O.A.M.F.T.E.), list it here:

Name of Institution:_____ Year granted:_____

Address: _____ Certificate area:_____

YOU MUST REQUEST THAT THE DEGREE-GRANTING INSTITUTION SEND AN OFFICIAL TRANSCRIPT FOR YOUR QUALIFYING DEGREE DIRECTLY TO THE BOARD OFFICE. APPLICATIONS CANNOT BE PROCESSED WITHOUT A VALID TRANSCRIPT.

Course Work Distribution List

(This page must be completed by applicants who do not have a master's degree in marriage and family therapy or in social work.)

Pursuant to N.J.A.C. 13:34-4.3(b), an applicant who does not have a master's degree in marriage and family therapy (M.F.T.) or in social work (M.S.W.) must demonstrate to the Board that he or she has completed the following courses as part of his or her studies for a master's degree:

Area		Course title	Hours (Indicate semester or quarter hours)	College/University
No. 1 Theoretical Foundations of Marriage and Family Therapy (a minimum of one graduate-level three-credit course equivalent to three semester hours)	a.			
	b.			
	c.			
	d.			
No. 2 Assessment and Treatment in Marriage and Family Therapy (a minimum of four graduate-level three-credit courses equivalent to 12 semester hours)	a.			
	b.			
	c.			
	d.			
No. 3 Human Development and Family Studies (a minimum of two graduate-level three-credit courses equivalent to six semester hours)	a.			
	b.			
	c.			
	d.			
No. 4 Ethics and Professional Studies (a minimum of one graduate-level three-credit course equivalent to three semester hours)	a.			
	b.			
	c.			
	d.			
No. 5 Research (a minimum of one graduate-level three-credit course equivalent to three semester hours)	a.			
	b.			
	c.			
	d.			
No. 6 Supervised Clinical Practice (a minimum of one graduate-level three-credit course equivalent to three semester hours)	a.			
	b.			
	c.			
	d.			
No. 7 Additional Courses (a minimum of one graduate-level three-credit course equivalent to three semester hours)	a.			
	b.			
	c.			
	d.			

Total hours _____

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CLINICAL M.F.T. SUPERVISION PLAN

Name of applicant:_____

Supervisor Information

_____
Last name First name Middle initial Other names if applicable

Business name: _____
Type of business (nonprofit, for profit, group, private, etc.)

_____
Business address

_____
City State ZIP code

Telephone number: _____ E-mail address:_____
(include area code)

ATTACH YOUR CURRENT RESUME/CIRRICULUM VITAE. IF YOUR SUPERVISOR IS LICENSED IN A STATE OR JURISDICTION OTHER THAN NEW JERSEY, CONTACT THE ISSUING LICENSING BOARD FOR VERIFICATION OF HIS/HER LICENSE. (Please note that the copying of N.J. license certificates is prohibited.)

Licensure of supervisor: (check all that apply)

☐ Marriage and Family Therapist ☐ Professional Counselor ☐ Psychologist ☐ Licensed Clinical Social Work
☐ Psychiatrist ☐ Family Physician ☐ Other _____

_____
Type of license or certificate Number State or jurisdiction issuing license or certificate Date issued/expired

_____
Type of license or certificate Number State or jurisdiction issuing license or certificate Date issued/expired

_____
Type of license or certificate Number State or jurisdiction issuing license or certificate Date issued/expired

_____
Type of license or certificate Number State or jurisdiction issuing license or certificate Date issued/expired

1. Have any of the supervisor's licenses ever been suspended, revoked or restricted? ☐ Yes ☐ No
   If "Yes," attach documentation and an explanation.

2. Where will client contact and supervision take place?

_____
Agency name Address Telephone number (include area code)

3. Does the proposed supervisor have any other individuals under clinical supervision? ☐ Yes ☐ No
If "Yes," give the number of supervisees:_____
(N.J.A.C. 13:34-3.4 sets the limit at six (6) licensure candidate supervisees.)

4. What is the proposed number of direct client contact hours you plan to meet WEEKLY?
Couples_____ Families_____ Individuals_____ Groups_____

5. What is the proposed number of hours of supervision you plan to meet WEEKLY?
Individual or Dyad (two people)_____ Group_____
(N.J.A.C.13:34-3.4(b) requires one hour of supervision for each five hours of client contact. One half of the supervision hours must be one-to-one or two-to-one.)

6. What are the proposed hours of work-related activities each week? _____
N.J.A.C. 13:34-8.1 allows six hours per week in work-related activities. "Work-related activities" are defined to include preparing and maintaining client records as described in N.J.A.C. 13:34-8.1 through 8.3, report writing, maintaining appointment schedules, communicating with other professionals, preparing for supervision, preparing and maintaining financial records in accordance with N.J.A.C. 13-34-5.3 and 6.1, and any other activities the qualified supervisor deems appropriate.

7. What are the inclusive dates with the above supervisor? Beginning: _____ Anticipated Ending: _____
month/day/year month/day/year

8. Describe the proposed client services you are contracting to provide (please include the applicant's detailed job description):

_____
_____
_____
_____
_____
_____
_____
_____

9. Has the applicant read the N.J. statute and regulations that accompany this application? ☐ Yes ☐ No
(N.J.S.A. 45:8b-1 et seq. and N.J.A.C. 13:34-1.1 et seq.)

10. Has the supervisor read the N.J. statutes and regulations that accompany this application? ☐ Yes ☐ No
(N.J.S.A. 45:8b-1 et seq. and N.J.A.C. 13:34-1.1 et seq.)

THESE DOCUMENTS ARE THE LEGAL DEFINITIONS FOR ANYONE WHO IS OR ASPIRES TO BE A LICENSED MARRIAGE AND FAMILY THERAPIST. FILE THEM FOR REGULAR GUIDANCE AND REFERENCE.

11. What are your personal learning objectives as you begin supervised client contact?

_____
_____
_____
_____

12. Will you have more than one supervisor in the above or another setting during the inclusive dates? ☐ Yes ☐ No
If "Yes," **complete another copy of the Clinical M.F.T. Supervision Plan** to provide the above-requested information regarding that supervisor.

_____ _____ _____
Applicant's signature Proposed supervisor's signature Date

Clinical References

Give the name and address of two professionally qualified individuals who know you well and who are in a position to evaluate your current clinical compliance in M.F.T.

Name	Address

Name	Address

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THREE-YEAR TEMPORARY PERMIT

CHECK-LIST

DID YOU REMEMBER TO INCLUDE:

☐ A completed permit application

☐ The clinical M.F.T. Supervision Plan

☐ A transcript (to be sent directly to the Board by the institution)

☐ The applicant's detailed job description

☐ The permit application fee

☐ Verification of the supervisor's M.F.T. or other license

☐ The supervisor's resume/curriculum vitae?

DO NOT RETURN THIS CHECK-LIST WITH YOUR APPLICATION. IT IS FOR YOUR OWN USE.

PLEASE MAKE A COPY OF YOUR APPLICATION FOR YOUR OWN RECORDS.

READ THE STATUTE AND THE REGULATIONS INCLUDED WITH THIS APPLICATION. FILE THEM CONVENIENTLY FOR REGULAR GUIDANCE AND REFERENCE.

SEMI-ANNUAL REPORT FORM

Complete the form to be found on the next two pages at the end of every six months of work with each supervisor and send a copy to the Board so that your progress can be monitored. At the completion of the required client contact and supervisory hours or at the completion of your supervision with this supervisor, submit this form for the entire period to the Board as part of your application for licensure.

Applicant _____ Supervisor_____

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Client Contact and Supervision Hours

This form allows for six (6) sets of hours reporting.

	Client Contact Hours					**Work Related**	**Supervision**	
Dates (Month/Year)	**Individuals**	**Couple (relational)**	**Family (relational)**	**Relational (add couple & family hrs.)**	**Total**	**Work Related Hours**	**Type of Supervision**	**Supervision Hours**
							Individual	
							Group	
Dates (Month/Year)	**Individuals**	**Couple (relational)**	**Family (relational)**	**Relational (add couple & family hrs.)**	**Total**	**Work Related Hours**	**Type of Supervision**	**Supervision Hours**
							Individual	
							Group	
Dates (Month/Year)	**Individuals**	**Couple (relational)**	**Family (relational)**	**Relational (add couple & family hrs.)**	**Total**	**Work Related Hours**	**Type of Supervision**	**Supervision Hours**
							Individual	
							Group	
Dates (Month/Year)	**Individuals**	**Couple (relational)**	**Family (relational)**	**Relational (add couple & family hrs.)**	**Total**	**Work Related Hours**	**Type of Supervision**	**Supervision Hours**
							Individual	
							Group	
Dates (Month/Year)	**Individuals**	**Couple (relational)**	**Family (relational)**	**Relational (add couple & family hrs.)**	**Total**	**Work Related Hours**	**Type of Supervision**	**Supervision Hours**
							Individual	
							Group	
Dates (Month/Year)	**Individuals**	**Couple (relational)**	**Family (relational)**	**Relational (add couple & family hrs.)**	**Total**	**Work Related Hours**	**Type of Supervision**	**Supervision Hours**
							Individual	
							Group	
Cumulative Total: (Add total hours down)								

Ratio of Supervision to Client Contact (1:5) = (Should equal .20 or greater. Divide total supervision hours by total client contact hours; individual supervision is 1 or 2 supervisees; group supervision is 3 to 6 supervisees.)

Other Work Activities

(Work-related activities have been briefly defined within the application. The list below takes that identification into specific activities and functions that an applicant may engage in as he/she works the program set out in the supervisory contract. They include any activities that are not involved in face-to-face client contact and supervision that a permit holder might be reasonably expected to have mastered in order to begin to practice independently. On the grid of 1 through 5, level 1 represents a beginning level of understanding and implementing the activity. Level 5 represents the level of mastery anticipated for licensure and a beginning of independent practice. If this rating is occurring at the completion of supervision with this supervisee, this rating should be final.

	1	2	3	4	5
Preparing a client file and structuring the information to be included in the record	_____	_____	_____	_____	_____
Maintaining client notes	_____	_____	_____	_____	_____
Preparing forms that meet H.P.P.A. requirements, N.J. Statutory and Regulation standards:					
Release of information forms	_____	_____	_____	_____	_____
Client records and reports	_____	_____	_____	_____	_____
Maintaining personal contact records	_____	_____	_____	_____	_____
Security of clinical recordings (if any)	_____	_____	_____	_____	_____
Careful disposal of trash	_____	_____	_____	_____	_____
Preparing treatment plans	_____	_____	_____	_____	_____
Writing reports	_____	_____	_____	_____	_____
Preparing insurance forms	_____	_____	_____	_____	_____
Maintaining appointment schedules	_____	_____	_____	_____	_____
Communicating with referral sources	_____	_____	_____	_____	_____
Communicating with other professionals	_____	_____	_____	_____	_____
Preparing and maintaining financial records	_____	_____	_____	_____	_____
Preparing for supervision	_____	_____	_____	_____	_____
Developing practice-related materials					
A variety of forms that facilitate the practice	_____	_____	_____	_____	_____
Advertising materials	_____	_____	_____	_____	_____
Business card	_____	_____	_____	_____	_____
Letterhead	_____	_____	_____	_____	_____
Announcements	_____	_____	_____	_____	_____
Other materials	_____	_____	_____	_____	_____
Other activities required by supervisor: specify					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I affirm the accuracy of this report:

Signature of Applicant: _____

I have read the statute (N.J.S.A. 45.8b-1 et seq.) and regulations (N.J.A.C. 13:34-1.1 et seq.) that accompany this application.

☐ Yes ☐ No

Signature of Supervisor: _____ Date: _____

☐ I concur that the above report is accurate and recommend this applicant to continue in his or her training for licensure.

☐ I do not recommend this applicant to continue in his or her training for licensure.

Comments: _____

_____

_____

This Semi-Annual Report form is available on the Board's Web site at:
www.njconsumeraffairs.com/medical/familytherapy.htm
You may print copies of it as needed.

Please make a copy of the Semi-Annual Report form for both the applicant's and the supervisor's records.

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____ } ss.

I, _____ , in making this application to the State Board of Marriage and Family Therapy Examiners for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the State Board of Marriage and Family Therapy Examiners, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Board.

I further swear (or affirm) that I have read N.J.S.A. 45:8B-1 et seq., together with the Rules and Regulations of the State Board of Marriage and Family Therapy Examiners, N.J.A.C. 13:34-1.1 et seq., and fully understand that in receiving licensure or certification from the Board, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board.

_____

Applicant's signature

Sworn and subscribed to before me this _____

day of _____ , _____

Month Year

_____

Name of Notary Public (please print)

_____

Signature of Notary Public

Affix Seal Here